

IPDR6702		NORTH CAROLINA				PAGE: 1		
RUN DATE: 09/25/2005		IPRS CHECKWRITE SUMMARY REPORT						
		CHECKWRITE DATE: 09/29/2005						
		FINANCIAL PAYER: NCDMM						
							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAIN M H/DD/SAS	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404904	WESTERN HIGHLAN DS LME	8599	181	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		143	18	CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE	1	223	6229	6006
		191	15	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
3404910	PATHWAYS	8599	2650	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		10	28	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR	1	2695	2793	98
		11	15	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404912	CATAWBA COUNTYM ENTAL HEALT	11	127	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		8599	2	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	1	132	551	419
		167	2	NO CHARGE BILLED. ENTER BILLED AMOUNT AND SUBMIT DETAIL AS A NEW CLAIM				
3404913	NECKLENBURG COM ENTAL HEALT	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	135	135
3404916	CROSSROADS BEHA VIOBAL HEAL	8621	82	60 RESIDENTIAL LEVEL III TREAT MENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.				
		21	68	DUPLICATE OF CLAIM-SYSTEM	5	312	6877	6565
		10	34	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID, DIAGNOSIS, PROCEDURE CODE FOR				
3404917	CENTERPOINT HUM AN SERVICES	21	6737	DUPLICATE OF CLAIM-SYSTEM				
		8599	680	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	136	8690	21260	12570
		8329	487	CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA				
3404918	ROCKINGHAM CO M ENTAL HEALT	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0

PROVIDER NUMBER	PROVIDER NAME	HIGH DENIAL EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	TOTAL CLAIMS FINALIZED	TOTAL CLAIMS PAID
3404919	GUILFORD CO MEN TAL HEALTHC	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	93	93
3404920	ALAMANCE CASWEL L AREA MH D	8599	160	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		5404	147	SEVERE DUPLICATE: SAME ATTD PR OV/PCODE/TOS/DOS/MOD	52	521	3521	3000
		21	91	DUPLICATE OF CLAIM-SYSTEM				
3404921	ORANGE PERSON C HATHAM AREA	8599	708	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		21	191	DUPLICATE OF CLAIM-SYSTEM	8	1218	7323	6105
		5312	115	PRIOR AUTHORIZED DOLLARS EXCEE DED				
3404922	THE DURHAM CENT ER	8329	60	CLAIM DENIED ATTENDING PROVIDE R CANNOT BE THE SAME AS THE LMA				
		191	1	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME	0	61	63	2
3404923	FIVE COUNTY MH	8622	65	60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.				
		8599	50	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	0	125	682	557
		191	4	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
3404925	SANDHILLS CENTE R FOR MH/DD	8599	273	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		21	177	DUPLICATE OF CLAIM-SYSTEM	47	829	8710	7881
		11	96	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404926	SOUTHEASTERN RE G MENTAL HL	8535	1592	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
		11	95	CLIENT NOT ELIGIBLE ON SERVICE DATE	16	1763	3145	1382
		8599	24	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
3404927	CUMBERLAND CO M HC	8599	108	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8649	13	CLAIM DENIED MAXIMUM ALLOWED 2 6 OCCURRENCES HAVE PROCESSED AND PAID, PA IS REQUIRED.	0	140	5292	5152
		21	10	DUPLICATE OF CLAIM-SYSTEM				

PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404929	LEE HARNETT MH/ DD/SAS	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404930	JOHNSTON COUNTY MNTL HLTHC	191	2	CLIENT ID NUMBER DOES NOT MATC H PATIENT NAME				
		0	0		0	2	55	53
3404931	WARE CO HUM SVC BILLING OF	11	188	CLIENT NOT ELIGIBLE ON SERVICE DATE				
		8599	99	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	15	395	5941	5546
		8622	32	60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.				
3404932	RANDOLPH/SANDHI LLS CO MH C	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404933	SOUTHEASTERN CT R FOR MH/DD	21	30	DUPLICATE OF CLAIM-SYSTEM				
		8599	15	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.	6	80	2188	2108
		11	11	CLIENT NOT ELIGIBLE ON SERVICE DATE				
3404934	ONSLow CARTERET BEHAV HEAL	8599	78	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		11	73	CLIENT NOT ELIGIBLE ON SERVICE DATE	1	263	875	612
		8535	68	SERVICE FACILITY LOCATION WAS NOT INCLUDED IN YOUR 837. PLEASE RESUBMIT YOUR CLAIM WIT				
3404935	WAYNE CO MENTAL HEALTH CTR	0	0	*** NO DATA TO REPORT ***				
		0	0		0	0	0	0
3404936	WILSON-GREENE M ENTAL HEALT	8599	114	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		8932	9	CMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	10	131	698	567
		21	5	DUPLICATE OF CLAIM-SYSTEM				
3404937	EDGEcombe NASH MNTL HLTH C	21	63	DUPLICATE OF CLAIM-SYSTEM				
		0	0		0	63	382	319

PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404938	YGFW DBA RIVERS	0	0	*** NO DATA TO REPORT ***				
	STONE COUNSEL							
		0	0		0	0	0	0
3404939	NEUSE MENTAL HE	8535	179	SERVICE FACILITY LOCATION WAS				
	ALTH CENTER			NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WITH				
		11	28	CLIENT NOT ELIGIBLE ON SERVICE	0	214	589	375
				DATE				
		8599	7	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404941	PITT CO MH/DD/S	8329	9	CLAIM DENIED ATTENDING PROVIDE				
	AS CENTER			R CANNOT BE THE SAME AS				
				THE LMA				
		191	7	CLIENT ID NUMBER DOES NOT MATC	0	17	75	58
				H PATIENT NAME				
		23	1	SERVICE REQUIRES PRIOR APPROVA				
				L				
3404942	ROANOKE CHOWANH	11	75	CLIENT NOT ELIGIBLE ON SERVICE				
	UMAN SERVIC			DATE				
		8599	59	DETAIL NOT COVERED BY COMBINAT	7	255	1780	1525
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		79	24	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
3404943	ALBEMARLE MENTA	8599	211	DETAIL NOT COVERED BY COMBINAT				
	L HEALTH CE			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8931	30	AMTNC INELIGIBLE TO RECEIVE SE	58	295	1035	740
				RVICES IN IPRS.				
		8935	28	ASTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404944	EASTPOINTE HUMA	21	103	DUPLICATE OF CLAIM-SYSTEM				
	N SERVICES							
		8599	10	DETAIL NOT COVERED BY COMBINAT	12	133	1789	1656
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8931	8	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404946	FOOTHILLS AREAM	0	0	*** NO DATA TO REPORT ***				
	ENTAL HEALT							
		0	0		0	0	84	84
3404957	TIDELAND MENTAL	23	44	SERVICE REQUIRES PRIOR APPROVA				
	HEALTH CTR			L				
		8599	13	DETAIL NOT COVERED BY COMBINAT	3	66	446	380
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	5	DUPLICATE OF CLAIM-SYSTEM				

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NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	PAID
3404979	NEW RIVER AREAM	8599	19	DETAIL NOT COVERED BY COMBINAT			
	H/DD/SA PRO			ION OF RECIPIENT, PROVIDER AND			
				BENEFIT PACKAGE.			
		120	11	CLIENT ID NUMBER MISSING OR IN	0	40	1960
				VALID. ENTER CID AND SUBMIT			1920
				AS A NEW CLAIM			
		21	10	DUPLICATE OF CLAIM-SYSTEM			